S-2577.3

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# SECOND SUBSTITUTE SENATE BILL 5930

**State of Washington 60th Legislature 2007 Regular Session**

**By** Senate Committee on Ways & Means (originally sponsored by Senators Keiser, Kohl-Welles, Shin and Rasmussen; by request of Governor Gregoire)

READ FIRST TIME 03/05/07.

AN ACT Relating to providing high quality, affordable health care to Washingtonians based on the recommendations of the blue ribbon commission on health care costs and access; amending RCW 7.70.060, 41.05.220, 48.41.110, 48.41.160, 48.41.200, 48.41.037, 48.41.100, 48.43.005, 48.41.190, 41.05.075, and 41.05.540; adding a new section to chapter 74.09 RCW; adding new sections to chapter 43.70 RCW; adding new sections to chapter 41.05 RCW; adding a new section to chapter 48.20 RCW; adding a new section to chapter 48.21 RCW; adding a new section to chapter 48.44 RCW; adding a new section to chapter 48.46 RCW; creating new sections; providing an effective date; providing an expiration date; and declaring an emergency.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

## USE STATE PURCHASING TO IMPROVE HEALTH CARE QUALITY

NEW SECTION. **Sec. 1.** The health care authority and the department of social and health services shall, by September 1, 2007, develop a five-year plan to change reimbursement within state purchased health care programs to:

(1) Reward quality health outcomes rather than simply paying for the receipt of particular services or procedures;

(2) Pay for care that reflects patient preference and is of proven value;

(3) Require the use of evidence-based standards of care where available;

(4) Tie provider rate increases to measurable improvements in access to quality care;

(5) Direct enrollees to quality care systems;

(6) Better support primary care and provide a medical home to all enrollees; and

(7) Pay for e-mail consultations, telemedicine, and telehealth where doing so reduces the overall cost of care.

The plan shall identify any existing barriers and opportunities to support implementation, including needed changes to state or federal law and be submitted to the governor and the legislature upon completion.

NEW SECTION. **Sec. 2.** The legislature finds that unwarranted variations in health care, variations not explained by illness, patient preference, or the dictates of evidence-based medicine, are a significant feature of health care in Washington state. There is growing evidence that, for preference-sensitive care involving elective surgery, the quality of patient-practitioner communication about the benefits, harms, and uncertainty of available treatment options can be improved by introducing high-quality decision aids that encourage shared decision making. The international patient decision aid standards collaboration, a network of over one hundred researchers, practitioners, patients, and policy makers from fourteen countries, have developed standards for constructing high-quality decision aids. The legislature declares an intent to focus on improving the quality of patient-practitioner communication and on increasing the extent to which patients make genuinely informed, preference-based treatment decisions. Randomized clinical trial evidence indicates that effective use of well designed decision aids is likely to improve the quality of patient decision making, reduce unwarranted variations in health care, and result in lower health care costs overall. Despite this growing body of evidence, widespread use of decision aids has yet to occur.

Barriers include: (1) Lack of awareness of existing, appropriate, high-quality decision aids; (2) poor accessibility to such decision aids; (3) low practitioner acceptance of decision aids in terms of compatibility with their practice, ease of use, and expense to incorporate into practice; (4) lack of incentives for use, such as reduced liability and reimbursement for their use; and (5) lack of a process to certify that a decision aid meets the standards required of a high-quality decision aid. The legislature intends to promote new public/private collaborative efforts to broaden the development, use, evaluation, and certification of effective decision aids and intends to support the collaborative through providing new recognition of the shared decision-making process and patient decision aids in the state's laws on informed consent. The legislature also intends to establish a process for certifying that a given decision aid meets the standards required for a high-quality decision aid.

NEW SECTION. **Sec. 3.** The state health care authority shall work in collaboration with the health professions and quality improvement communities to increase awareness of appropriate, high-quality decision aids, and to train physicians and other practitioners in their use. The effort shall focus on one or more of the preference-sensitive conditions with high rates of unwarranted variation in Washington, and can include strategies such as prominent linkage to such decision aids in state web sites, and training/awareness programs in conjunction with professional and quality improvement groups. The state health care authority shall, in consultation with the national committee for quality assurance, identify a certification process for patient decision aids. The state health care authority may accept donations or grants to support such efforts.

NEW SECTION. **Sec. 4.** The state health care authority shall work with contracting health carriers and health care providers, and a nonproprietary public interest research group and/or university-based research group, to implement practical and usable models to demonstrate shared decision making in everyday clinical practice. The demonstrations shall be conducted at one or more multispecialty group practice sites providing state purchased health care in the state of Washington, and may include other practice sites providing state

purchased health care. The demonstrations must include the following elements: Incorporation into clinical practice of one or more decision aids for one or more identified preference-sensitive care areas combined with ongoing training and support of involved practitioners and practice teams, preferably at sites with necessary supportive health information technology. The evaluation must include the following elements: (1) A comparison between the demonstration sites and, if appropriate, between the demonstration sites and a control group, of the impact of the shared decision-making process employing the decision aids on: The use of preference-sensitive health care services; and associated costs saved and/or expended; and (2) an assessment of patient knowledge of the relevant health care choices, benefits, harms, and uncertainties; concordance between patient values and care received; and satisfaction with the decision-making process and their health outcomes by patients and involved physicians and other health care practitioners. The health care authority may solicit and accept funding to support the demonstration and evaluation.

**Sec. 5.** RCW 7.70.060 and 1975-'76 2nd ex.s. c 56 s 11 are each amended to read as follows:

(1) If a patient while legally competent, or his or her representative if he or she is not competent, signs a consent form which sets forth the following, the signed consent form shall constitute prima facie evidence that the patient gave his or her informed consent to the treatment administered and the patient has the burden of rebutting this by a preponderance of the evidence:

((~~(1)~~)) (a) A description, in language the patient could reasonably be expected to understand, of:

((~~(a)~~)) (i) The nature and character of the proposed treatment;

((~~(b)~~)) (ii) The anticipated results of the proposed treatment;

((~~(c)~~)) (iii) The recognized possible alternative forms of treatment; and

((~~(d)~~)) (iv) The recognized serious possible risks, complications, and anticipated benefits involved in the treatment and in the recognized possible alternative forms of treatment, including nontreatment;

((~~(2)~~)) (b) Or as an alternative, a statement that the patient

elects not to be informed of the elements set forth in (a) of this subsection ((~~(1) of this section~~)).

(2) If a patient while legally competent, or his or her representative if he or she is not competent, signs an acknowledgement of shared decision making as described in subsection (3) of this section, such acknowledgement shall constitute prima facie evidence that the patient gave his or her informed consent to the treatment administered and the patient has the burden of rebutting this by clear and convincing evidence. An acknowledgement of shared decision making shall include:

(a) A statement that the patient, or his or her representative, and the health care provider have engaged in shared decision making as an alternative means of meeting the informed consent requirements set forth by laws, accreditation standards, and other mandates;

(b) A brief description of the services that the patient and provider jointly have agreed will be furnished;

(c) A brief description of the patient decision aid or aids that have been used by the patient and provider to address the needs for (i) high-quality, up-to-date information about the condition, including risk and benefits of available options and, if appropriate, a discussion of the limits of scientific knowledge about outcomes; (ii) values clarification to help patients sort out their values and preferences; and (iii) guidance or coaching in deliberation, designed to improve the patient's involvement in the decision process;

(d) A statement that the patient or his or her representative understands: The risk or seriousness of the disease or condition to be prevented or treated; the available treatment alternatives, including nontreatment; and the risks, benefits, and uncertainties of the treatment alternatives, including nontreatment; and

(e) A statement certifying that the patient or his or her representative has had the opportunity to ask the provider questions, and to have any questions answered to the patient's satisfaction, and indicating the patient's intent to receive the identified services.

(3) "Shared decision making" means a process in which the physician or other health care practitioner discusses with the patient or his or her representative the information specified in subsection (1)(a) of this section, with or without the use of a patient decision aid, and the patient shares with the provider such relevant personal information

as might make one treatment or side effect more or less tolerable than others. The goal of shared decision making is for the patient and physician or other health care practitioner to feel they appropriately understand the nature of the procedure, the risks and benefits, as well as the individual values and preferences that influence the treatment decision, such that both are willing to sign a statement acknowledging that they have engaged in shared decision making and setting forth the agreed treatment to be furnished.

(4) "Patient decision aid" means a written, audio-visual, or online tool that provides a balanced presentation of the condition and treatment options, benefits, and harms, including, if appropriate, a discussion of the limits of scientific knowledge about outcomes, and that is certified by one or more national certifying organizations approved by the health care authority. In order to be an approved national certifying organization, an organization must use a rigorous evaluation process to assure that decision aids are competently developed, provide a balanced presentation of treatment options, benefits, and harms, and are efficacious at improving decision making.

(5) Failure to use a form or to engage in shared decision making, with or without the use of a patient decision aid, shall not be admissible as evidence of failure to obtain informed consent. There shall be no liability, civil or otherwise, resulting from a health care provider choosing either the signed consent form set forth in subsection (1)(a) of this section or the signed acknowledgement of shared decision making as set forth in subsection (2) of this section.

**PREVENTION AND MANAGEMENT OF CHRONIC ILLNESS**

NEW SECTION. **Sec. 6.** A new section is added to chapter 74.09 RCW to read as follows:

(1) The department of social and health services, in collaboration with the department of health, shall:

(a) Design and implement medical homes for its aged, blind, and disabled clients in conjunction with chronic care management programs to improve health outcomes, access, and cost-effectiveness. Programs must be evidence based, facilitating the use of information technology to improve quality of care, and must improve coordination of primary, acute, and long-term care for those clients with multiple chronic